DEPARTMENT OF HUMAN SERVICES - OFFICE OF REHABILITATION SERVICES
40 Fountain Street ~ Providence, RI 02903 ~ (401) 421-7005 (V) ~ (401) 421-7016 (TTY)
"Helping individuals with disabilities to choose, find and keep employment"

AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION

DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my record. *(Name of Client)*

My Date of Birth: _____ / _____ / _____ My Social Security Number: _____ - _____ - _____

II. My information is to be disclosed to/ provided by:

_____
Name of Person/Organization

_____
Address

_____
City/ST/Zip

And is to be provided to/disclosed by:

_____
Name of Person/Organization

_____
Address

_____
City/ST/Zip

III. The purpose or need for this release of information is:

☐ To obtain the information checked below that will assist me in vocational rehabilitation planning
☐ My own personal and private reasons
☐ Other (*specify*): _____

IV. The information to be disclosed from my health record: (*check all of the boxes that apply*)

☐ Vocational ☐Medical ☐Educational ☐Social
☐ Financial ☐ Psychiatric/Psychological ☐Other (*specify*): _____
☐ **Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)**

Specific Information Needed: _____

Dates of Service: _____ to _____

I would also like the following sensitive information disclosed: (*check the applicable box*(*es*))

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases

V. I understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES/OFFICE OF REHABILITATION SERVICES (DHS/ORS) and that, if I do, DHS/ORS may condition my access to services on my decision to revoke. In addition, any information disclosed to DHS/ORS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below. Any information released or received as a result of this consent shall not be further relayed in any way to any person or organization outside the Department of Human Services without additional written consent from me.

_____
(Enter if different from one year after the date below)

_____ _____
Signature of Client **Date**

_____ _____ _____
Signature of Authorized Representative **Relationship to the Client** **Date**

Instructions for Completing Form ORS-37

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.

2. Section I **–** print name of the client whose information is to be released.

3. Section II **–** print the name and address of the person or organization authorized to release and/or receive the information. Also, provide the name of the DHS/ORS representative, unit and address that will receive and/or release the information.

4. Section III **–** state the reason why the information is needed (e.g., disability claim, continuing medical care)

5. Section IV **–** check all of the boxes that apply.

    a. Vocational, Medical, Educational, Social, Financial, Psychiatric/Psychological

    b. Other *(specify)* – specific information identified by the client (e.g., billing, employee health)

    c. Psychotherapy Notes **ONLY** – in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.

    Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

    d. Specific Information Needed – clearly identify the precise information to be disclosed.

    e. Dates of Service – note the first and last date of service requested.

    f. RELEASE OF SENSITIVE INFORMATION **–** check alcohol-drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases – patient must check the appropriate box!

6. Section V – sign and date. If a different *expiration* date is desired, specify a new date.

7. Section V – Authorized Representative (e.g., parent, legal guardian, power of attorney)

8. A copy of the completed Form ORS-37 will be given to the client.